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AUTHOR Craig, Rebecca T.; Paterson, Andrea
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ABSTRACT

Involuntary commitment laws, once seen as reform, now questioned as roadblocks to needed treatment, are discussed. The ineffectiveness of state's commitment laws, lack of community resources for treating the mentally ill, and homelessness among the mentally ill are discussed in the introduction. The history of the right of a state to commit individuals involuntarily is presented. This right is derived from the power of a state to protect society from dangerous persons and the power to act as parent or in the best interest of its citizens. Four factors which spurred commitment law reform, including abuse of the power, institutional crowding, deinstitutionalization, and the move to clarify minority rights are discussed. Legislative guidelines are given, including just commitment and due process. Specific state commitment laws are presented. Future directions for commitment laws are discussed which emphasize an adaptable instead of adversarial posture for the states. A case study of South Carolina is included. (ABL)

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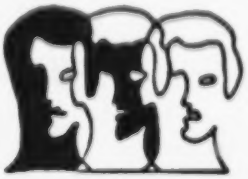

MENTAL HEALTH PROJECT

Human Resources Series

STATE INVOLUNTARY COMMITMENT LAWS: BEYOND DEINSTITUTIONALIZATION

by

Rebecca Craig and Andrea Paterson

Vol. 10, No. 6 August, 1985

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STATE INVOLUNTARY COMMITMENT LAWS: BEYOND DEINSTITUTIONALIZATION

INTRODUCTION

According to the Institute of Medicine, mental illness, alcoholism, and drug addiction affect the lives of roughly 30 to 45 million people in the United States each year. The costs to society are immense: in direct health care expenditures, conservative estimates start at $20 billion per year; estimates of total economic impact soar to $185 billion per year (1, p. 1). Yet the costs to those affected are immeasurably greater. Few would presume to assess the cost of a life lived in the private twilight of mental illness, or in a haze of alcohol or drugs.

States cannot avoid the economic and human costs of mental illness and substance abuse. Yet the involuntary commitment laws for the mentally ill and the substance abuser are often inadequate and ineffective in the task of procuring proper treatment for these individuals.

According to the American Psychiatric Association, there were 559,000 patients in state hospitals in 1955. On any given day today, there are approximately 132,000 (2, p. 62). But not all of these formerly institutionalized individuals have found life significantly better in the community. In fact, many people attribute today's civil commitment problems to the well-intentioned reforms that followed the deinstitutionalization movement of the 1960s and 1970s.

With respect to the commitment of mentally ill adults, many mental health practitioners and families find today's laws too complicated. Safeguards have been written into most state laws that guarantee a familiar listing of rights, derived largely from criminal procedures: right to have access to general, legal, and treatment information; right to counsel; right to cross-examine; right to a hearing and to planned and monitored treatment; etc. Yet for many, these rights and safeguards have turned the civil commitment process into a procedural maze and a roadblock for those needing treatment.

In addition, the lack of community resources--of least restrictive alternatives for the treatment of the mentally ill person--has prompted a recent move back toward institutionalization. Homelessness among the mentally ill has been a driving force. In the words of the American Psychiatric Association, the true rights of the mentally ill are not served by laws so complex that they sometimes work against the treatment needs of the patient; in short, "patients' rights to freedom are not synonymous with releasing them to the streets where they cannot take care of themselves" (2, p. 62). The growth of family alliance groups for the mentally ill during the last five years also points to a growing--and organized--concern over the need for <u>some</u> type of treatment for those mentally ill most in need.

With respect to children and substance abusers, the problems of today are, in many ways, new faces on the problems that have existed all along. For mentally ill children, a lack of adequate facilities and coordinated services, along with few statutory articulations of children's mental health needs, has stood in the way of adequate and appropriate treatment. For substance abusers, the lack of adequate treatment programs and facilities,

along with a lack of adequate law embracing the particular problems of the substance abuser, continue to make the road to treatment difficult.

A HISTORICAL PERSPECTIVE: THE RIGHT OF THE STATE TO COMMIT INDIVIDUALS INVOLUNTARILY

The state has two basic powers that enable it to hospitalize a mentally ill person or substance abuser against his or her will. The first of these is police power: the right of the state to protect its at-large members from harm threatened by a "dangerous" member of that state. The second power involves the state's role as the "parent" of its "children/citizens." *Parens patriae* means literally the "father of the country" and delegates to the state the right to act in the best interests of its citizens. States have traditionally used these two basic powers to assist them in formulating criteria upon which involuntary commitment decisions can be based.

Dangerous to Others. The requirement that a person be dangerous to others is a major commitment criterion for adults in many states.

- Every state except New Jersey has this "dangerousness" provision in its civil commitment statute (3, chap. 2).

- 25 states require a person to be dangerous to society before he or she can be involuntarily committed (3, chap. 2).

- 24 states provide for "dangerous to self or others" as an additional or alternative criterion for involuntary commitment (3, chap. 2).

The standard of dangerousness is also used in the commitment of children and substance abusers. In the case of children, separate commitment laws, in the few states where they exist, are frequently modeled on adult laws and thus often provide for "dangerousness" as a central commitment criterion. For substance abusers, a few states have supplanted the standard danger-to-self criterion with that of dangerousness to others.

Involuntary commitment based on the state's police power--and obligation--to protect its citizens raises serious constitutional issues. The Constitution guarantees that an individual's liberty shall not be taken away without full due process; without, in short, just cause. One due process question raised by commitment proceedings involves the justness of taking liberty away because of an individual's potential dangerousness to other members of society. This constitutional question becomes particularly troubling in light of the fact that the mentally ill, as a group, "are no more dangerous than the general population" (3, chap. 2), and the medical community has difficulty determining which individuals are dangerous.

Furthermore, while the "dangerous" substance abuser cannot be pinpointed, the actual user can be determined by way of sophisticated medical tests. Such scientifically based tests to determine use can complicate the guesswork of determining dangerousness. A petitioner's claim, for example, that an individual was a dangerous substance abuser could be discredited by test results indicating that the individual subject to commitment had not, in fact, used drugs or alcohol in the recent past.

A second constitutional question is raised by the sometimes inappropriate "punishment" of the mentally ill and substance abuser through involuntary civil commitment. Especially during emergency commitment proceedings,

an actual or threatened act of violence generally prompts the formal commitment action. Yet these acts of violence, however frightening or disruptive, are often relatively minor. Still, the mentally ill or substance abusing individual can end up institutionalized for extended periods of time, especially in states with provisions for open-ended commitment. The justness of such commitment is particularly questionable in the case of substance abusers who, as a rule, require much less long-term care than the chronically mentally ill.

No less troubling is the question of what constitutes a "danger to others." The courts and the statutes have gone back and forth on the question of whether there must be an overt act of violence, or merely the threat of violence, before a person can be involuntarily hospitalized. In addition, states have struggled to address the question of whether or not an individual's dangerousness to property constitutes grounds for civil commitment.

Dangerous to Self. The right of the state to act as a "parent" to one of its "children" has gone from being the basis of almost all commitment decisions to being only a criterion of equal importance with that of "dangerous to others." In fact, many state statutes consider both commitment criteria in the inclusive "dangerous to self or others" statutory language.

The basic idea behind *parens patriae* is that the state must act to help and protect its citizens.

- Most states have replaced the previously common "in need of treatment" standard with "dangerous to self," variously defined from attempted suicide to an inability to provide for basic needs of food, clothing, and shelter.

- At least nine states (3, chap. 2) have added the specific criterion of "gravely disabled" to their statutes in the last few years, thus providing for commitment expressly based on a grave inability to provide for one's basic needs. Two-thirds of the states have a criterion of "gravely disabled" in one form or another.

Such grave disability is often cited in cases involving the homeless mentally ill. Family alliance groups have often been instrumental in getting this specific commitment criterion, spurred by concern for mentally ill family members unable to care adequately for themselves. Commitment based upon grave disablity, however, does not guarantee that adequate treatment will be available to the individual once he or she is hospitalized.

With respect to children, the primary criterion for commitment has traditionally been "danger to self," as indicated by the fact that, "as late as the mid-1970's, three-quarters of the states had special statutory provisions whereunder parents could commit their children to mental hospitals without a court hearing or lesser form of judicial oversight" (3, chap. 2).

In regard to substance abusers, the only element common to all of the state statutes that specifically address substance abusers is the reference to habit or frequency of abuse--a statutory element that implies a dangerous-to-self orientation (3, chap. 2).

Commitment based on *parens patriae* criteria has its own set of constitutional concerns. Through the middle of the 20th century, the opinion of one

person was often sufficient to get another person committed. In the case of adults, this power was generally vested in the physician; for children, in the parents; and for substance abusers, in the petitioner interested in having the substance abuser "put away." Serious due process questions were raised about the system that allowed for the indefinite deprivation of liberty based upon someone's opinion that an individual was "in need of treatment." The criteria of "dangerous to self" and "gravely disabled" are less likely to be subject to constitutional challenge at present, as the "in need of treatment" standard was successfully challenged in the past for being unconstitutionally broad.

Parens patriae also draws into focus the treatment system in which the committed individual will presumably be placed. What are the prospects of the committed individual being helped by the system? Without a reasonable guarantee that a person will be helped, one can argue that the basis for such "in need of treatment" commitment disintegrates. And the burden of deciding this constitutional question is not eased by "the persisting, if gradually closing, gaps in the medical knowledge that informs the treatment of mentally disabled persons and the deficiencies in many of the public institutions where such treatment or care is sought to be provided" (3, chap. 2). Nor is this burden eased by the treatment tools available. In the case of substance abusers, drugs such as antabuse, commonly used in alcoholism treatment programs, can severely affect the person being treated. And users of anti-psychotic medications can suffer severe and often permanent side effects.

Furthermore, the U.S. Supreme Court, while it has upheld the state's police power to commit, addressed itself to the right of the state to treat a person against his or her will in O'Connor vs. Donaldson [422 U.S. 563, 95 S.Ct., 2486, 45 L. Ed., 2d 396]. In this case, the Court stated: "A State cannot constitutionally confine without more [i.e. - without more than mere custody] a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."

THE MOVEMENT TOWARDS REFORM: COMMITMENT LAWS THROUGH THE MID-1970s

Four primary factors spurred commitment law reform in the 1950s through the mid-1970s:

- the abuse of the state's powers to commit individuals involuntarily;
- the conditions in the institutions;
- the movement toward deinstitutionalization of the mentally ill;
- the society-wide push to litigate and clarify the rights of minority populations.

Prior to this era of reform, the states' institutions had often served as warehouses for mentally ill adults and children. Commitment standards could be perilously broad, resulting in inappropriate hospitalization until the person was "cured." Moreover, individuals so committed were subject to minimal medical and periodic review. Thus they were easily--and often--lost in the state hospital systems, brought to life for the first time by horror stories of abuse.

For substance abusers, whether "dangerous" or "in need of treatment," there were few treatment opportunities. A family could scramble for years to get a member into a service program that offered some hope for help. And then the hope was often tethered to a diagnosis of mental illness and to treatment in a psychiatric facility.

The deinstitutionalization movement, however, provided the greatest push toward revision of state civil commitment laws. The movement's medical and philosophical underpinnings included the advent of the new psychoactive medications and a general belief that "treatable" people would receive better treatment in the community. Yet it was, in fact, the 1963 passage of the federal "Mental Retardation Facilities and Community Mental Health Centers Construction Act," coupled with first-time categorical federal aid to the disabled, that officially geared up the deinstitutionalization machinery. The Community Mental Health Centers Act was "a strong incentive to the development of community programs with the potential to treat people whose main recourse previously had been the state hospital" (2, p. 61).

One of the most notable reforms accompanying deinstitutionalization involved the introduction of "least restrictive alternative" language into both the state statutes and the practices and philosophical leanings of the state mental health systems. The least restrictive alternative standard was first articulated in the mental health field in Lake v. Cameron, a 1966 case from the Washington, D.C., Circuit Court [364 F. 2d 657 (D.C. Cir. 1966)]. In Cameron, the Court ruled that "deprivations of liberty solely because of dangers to the ill persons themselves should not go beyond what is necessary for their protection." Furthermore, in 1972 a Wisconsin federal court handed down an opinion in Lessard v. Schmidt that required more procedural safeguards to protect those subject to involuntary commitment [349 F. Supp. 1078 (E.D. Wis. 1972)].

In addition to affording due process safeguards largely derived from criminal procedures, state commitment laws also began to specify who could initiate commitment proceedings and on what grounds and to delineate the different types of involuntary commitment proceedings. These efforts paralleled civil rights reforms that were occuring across the country for women and minorities.

GENERAL LEGISLATIVE GUIDELINES

While many debate the proper way to approach revision of civil commitment laws, there does seem to be a general consensus on certain points among mental health practitioners, consumers, and their families.

- The courts must be able to determine whether or not civil commitment is, in fact, appropriate for a given individual; to help insure that a solid decision is made, state laws can be revised to isolate those groups that are often the most appropriate subjects for commitment among mentally ill adults and children and substance abusers.

- The commitment process must be just; state laws can be revised to insure hospitalization only in those circumstances where it is likely to do the person some good.

- The procedural elements of a commitment law should guarantee individuals adequate due process protection during the admissions, treatment, and discharge periods; laws can be revised to offer due process

safeguards, such as adequate screening prior to admission, periodic review during treatment, and adequate case management following release from the hospital.

- Involuntary commitment is only part of a state's mental health service system; laws are best revised only after the state's total mental health service delivery system has been reviewed.

In addition, a number of organizations have adopted "model" commitment laws. However, model laws or guidelines produced by different groups can be sharply at odds over fundamental issues in the civil commitment process. As noted by the National Center for State Courts, "the most distinguishing characteristic of the involuntary civil commitment process may well be the sharp disagreement over virtually all issues relating to it" (4, p. 16).

Model legislation and guidelines for the commitment of mentally ill minors and adults have been developed or are under development at the American Psychiatric Association, the Mental Health Law Project, and the National Center for State Courts. The National Conference of Commissioners on Uniform State Laws has developed model laws for alcohol and drug abusers.

THE STATES' RESPONSE IN RECENT YEARS

As Bick Wanck demonstrates in "Two Decades of Involuntary Hospitalization Legislation," legislative changes to commitment laws over the last 20 years have made a significant difference in the number of people admitted to and treated in state mental hospitals. The trend in the late '60s and early '70s toward increased judicial safeguarding and more restrictive admissions criteria produced a measurable decrease in the number of people admitted to state hospitals, just as the more recent trend toward a relaxing of state commitment laws has resulted in an increase (5, p. 33).

Recent Changes In Laws For Commitment Of Adults. During the last several years, at least 34 states have considered revising or have revised their adult commitment laws. At least three of those states, Kansas, New Jersey, and Virginia, considered sweeping changes, and at least one state, Washington, studied its commitment law in-depth. Moreover, a number of states have facilitated commitment either by broadening commitment criteria or by easing judicial safeguards.

In 1985, Hawaii expanded its commitment criteria to include "gravely disabled" individuals, meaning mentally ill persons unable to provide for their basic personal needs for food, clothing, or shelter, to make rational or responsible decisions concerning their welfare, or to understand that they lack this capacity (1985 Hawaii Sess. Laws, act #75). California and New York considered similar measures.

During the 1983 and 1985 sessions, the Arizona legislature passed bills that greatly liberalized the state's commitment law. The 1983 bill rewrote a number of the commitment law's safeguards in more general terms (1983 Ariz. Laws, chap. 253). For example, an individual was no longer required to act in a way indicating a potential for "substantial bodily harm" to himself or another "within [the] 30 days" prior to or following the commitment proceedings; instead, "serious physical harm" had only to be imminent within "the near future" or threatened "in the recent past by verbal or nonverbal acts or both." The 1985 bill further liberalized the commitment criteria by striking all references to conditions or indicators of mental

illness "in the recent past" or in "the near future" (1985 Ariz. Laws, chap. 363). The new law stipulates only that, as a result of mental illness, the person's "continued behavior can reasonably be expected...to result in serious physical harm."

North Carolina, over the past decade, has moved generally away from its 1973 legislation providing comprehensive and strict procedural protection for people involved in commitment proceedings (1973 N.C. Sess. Laws, chap. 726). Under present law, it is significantly easier to commit a mentally ill person.

Minnesota made sweeping changes to its commitment law with the passage of its Minnesota Commitment Act of 1982 (1982 Minn. Laws, chap. 253B). Kentucky, during the 1982 session, passed a bill that strengthened the due process protections of those considered for involuntary commitment, while still making it easier for mental health professionals to provide treatment and evaluation under the law (1982 Ky. Acts, chap. 445).

Recent Changes In Laws For The Commitment Of Children. During the last several years, at least 11 states have considered or have made changes in their laws relating to the commitment of children. Such changes have included, but are not limited to, establishing separate facilities, procedures, or statutes that address comprehensively the commitment needs of mentally ill children.

In 1983, Montana established the Montana Youth Treatment Center for the care and treatment of "seriously mentally ill" youth, between 12 and 18 (1983 Mont. Laws, chap. 363). Initial commitment is for three months, although it may be extended for an initial six months and then yearly thereafter. Mentally ill youth, other than delinquent youth, can no longer be committed to the state hospital for adults. In Florida, effective July 1, 1983, minors entering the state hospital must be separated from adults, and children must be separated from adolescents (1982 Fla. Laws, chap. 82-212).

Michigan has established a separate statute outlining commitment criteria and procedures for mentally ill children under 18 years of age (1984 Mich. Public Acts, act #186). A minor is deemed "suitable for hospitalization" if the minor is "emotionally disturbed...requires mental health treatment and is expected to benefit from hospitalization" and if there is no reasonable, less restrictive alternative. The Michigan law also sets up a single port of entry/single exit system through which requests for both the voluntary and the involuntary hospitalization of a minor must pass, with the community mental health center director acting as the gatekeeper.

Nebraska enacted, in 1983 (1983 Neb. Laws, L.B. # 389), a similar comprehensive statute addressing the commitment needs of minors. The statute protects minors against needless hospitalization while still recognizing the right of the parents to make medical decisions on their child's behalf. Washington passed a similarly comprehensive bill (1985 Wash. Laws, chap. 354), the purpose of which was to ensure that minors "in need of mental health care and treatment receive appropriate care and treatment." Minnesota may soon consider legislation which virtually abolishes the practice of "voluntary" commitment of children, which allows them to be committed by their parents without a neutral review.

Recent Changes In Laws Relating To Substance Abusers. At least 10 states have considered or passed legislation addressing the treatment needs of the substance abuser.

During 1983, the Arizona Legislature passed a bill establishing, for chronic alcoholics, separate commitment criteria based on chronicity and incapacitation, separate commitment procedures, and various concrete treatment options, including mandatory outpatient treatment (1983 Ariz. Laws, chap. 120). The new law attempts to deal with the "revolving door" problem among alcoholics by allowing for commitment based upon evidence of previous admissions.

In Texas, two bills passed during the 1985 session that address the treatment needs of alcohol and drug abusers respectively. The first bill is designed to eliminate the admission of alcohol abusers to the state mental hospitals and to mandate the development of a community-based detoxification and residential program for the treatment of chronic alcoholics (1985 Tex. Gen. Laws, SCR 64). The second bill makes it easier to have a drug-dependent person committed, but strengthens certain due process protections (1985 Tex. Gen. Laws, chap. 308). The courts can now order commitment if the person is determined to be drug-dependent and in need of hospitalization "for his own welfare and protection or for the protection of others." Previous law required the person to be drug-dependent and in need of hospitalization and "restraint." The new law also protects against undue continuation of hospitalization by enacting a maximum commitment period of six months, instead of the previously allowed commitment of such duration as "may be necessary to arrest the person's drug dependency."

Nebraska passed a bill during 1985 that delineates separate commitment procedures to be followed in the commitment of drug abusers in that state (1985 Neb. Laws, L.B. #252). And Minnesota, as part of its sweeping 1982 Minnesota Commitment Act, provided a specific definition of a "chemically dependent person" and outlined procedures for their involuntary commitment (1982 Minn. Laws, chap. 253B).

North Dakota significantly eased the admissions procedures for cases involving substance abusers with the passage of a bill during its 1985 session (1985 N.D. Sess. Laws, chap. 308). The bill expanded the list of those "independent expert examiners," chosen by the patient, and those "expert examiners," appointed by the court, to include "a master addiction counselor," whose role is limited to determining "whether the respondent is an alcoholic or a drug addict."

FUTURE DIRECTIONS

It is clear that states are moving in the direction of easing judicial safeguards and broadening commitment standards. Moreover, states are focusing less and less on the confrontational, formal commitment procedures and more on adaptable courtroom procedures that increase cooperation among the parties involved.

Such efforts promoting appropriate treatment include:

- pre-trial investigation, review, and settlement of charges that led to commitment action;

- pre-hearing screening that allows for referral to alternatives other than inpatient hospitalization at a very early stage in the legal process. The Minnesota commitment law provides for both pre-petition and pre-hearing screening;

- comprehensive testing of individuals referred for commitment, designed to rule out the possibilty of an organic or substance abuse problem masquerading as a mental illness. Such testing already occurs in Oregon and is under consideration in a handful of others states, including Colorado, South Carolina, and Washington.

This greater emphasis on adaptable, instead of highly adversarial and formal, commitment procedures reflects a growing state understanding of the need for appropriate care and treatment of the disabled person. Still, one must remember that state efforts to ease commitment standards are not always in harmony with a greater emphasis on appropriate care and treatment. Easing commitment criteria can channel more money to the state hospitals and less to continuity of care. Furthermore, many states are starting to erect safeguards that guarantee children the right to contest their commitment by parents or guardians.

States are also acting to offer concrete alternatives to inpatient care, thus easing the burden--both financial and emotional--of improper placement in hospitals of those mentally ill who are clearly in need of treatment but not "commitable" by most state standards.

- Involuntary outpatient treatment, already possible under specific out patient treatment laws in Georgia, Hawaii, and North Carolina, and under consideration in a handful of other states, including Arkansas, Kansas, Montana, Oregon, and Pennsylvania, enables the courts to compel outpatient treatment for those mentally ill individuals who need treatment but who are incapable of deciding voluntarily to seek or comply with treatment orders. Involuntary outpatient treatment is theoretically possible in over half of the states, under laws without detailed outpatient commitment procedures.

- Montana is considering mandating involuntary treatment in the local community for persons who are not considered a danger to themselves or others, along with confirmation that adequate treatment is unavailable in the community before a person can be admitted to the state hospital.

- General hospital services, with intensive care units serving short- and long-term patients, have been developed to meet the needs of those mentally ill who require a higher level of care than the community mental health system can provide.

- Community-based crisis units and housing facilities are being developed to avoid commitment of those mentally ill who have extreme--but infrequent--crisis episodes and require only short-term stabilization before returning to the community.

States are also striving to meet some of the treatment needs of the traditionally underserved chronically mentally ill, while striving to explore new ways of financing such necessary treatment alternatives.

- Wisconsin has taken the initiative to reduce the number of people using inpatient facilities by expansion of community mental health ser-

vices, an expansion that in turn reduces the demand for other mental health and human service needs.

- Georgia and the District of Columbia are considering mandatory treatment for those individuals frequently and consistently using inpatient services, by way of legislation specifically designed to deal with "revolving door" patients .

- Illinois is one state considering the possiblity of an income tax check-off as a way to fund needed service alternatives.

- Montana has passed a bill authorizing an increase in the taxes on beer and wine, earmarking part of the increase for alcoholism treatment programs. Similar measures are under consideration in Tennessee and Wisconsin. Hawaii is considering various measures that would help finance and give an overall focus to its treatment of substance abusers. The state is considering financing treatment facilities for alcohol abusers, in part, from surcharges on county liquor commission funds, and requiring compliance with certain licensing criteria mandatory before a program can receive public funds.

The failure to develop such adequate alternatives might well result in increased visibility and prevalence of the mental health system's most failed population: the chronically mentally ill. Without the efficient and effective use of resources, states can well expect an increase in problems with homelessness and with "revolving door" institutional problems.

These problems, however, can be mitigated through development of presently available alternatives to involuntary hospitalization. Indeed, in the eyes of many, focus upon legislative reform rather than upon improving existing treatment options will leave unaddressed the key problems facing the mentally ill. Involuntary commitment has certainly been used, in the past, as an inappropriate--but available--treatment option when limited, alternative treatment options existed. Yet few in the mental health field would dispute that involuntary civil commitment should be viewed as a single element within a wide and comprehensive range of options that states can develop.

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CASE STUDY: SOUTH CAROLINA INVOLUNTARY CIVIL COMMITMENT

INTRODUCTION

In 1983, the South Carolina Legislative Audit Council (LAC) reviewed the South Carolina Department of Mental Health and identified potential problems with the state's involuntary commitment law. As the Legislature's Mental Health and Mental Retardation Committee was without staff, the Senate Medical Affairs Committee formed a task force to study the state's commitment law. Although the task force submitted two drafts of legislation to amend the existing commitment law, neither was well received. The task force subsequently submitted a report to the Mental Health and Mental Retardation Committee regarding the problems found in the LAC report and additional problems discovered through research.

The Mental Health and Mental Retardation Committee divided into three subcommittees to focus on the state's commitment laws relating to mentally ill adults and children and to substance abusers. The subcommittee on adult commitment held one day of public hearings and drew up recommendations based upon the LAC report, public testimony received during the hearing, and research. The children's subcommittee appointed an ad hoc committee on children and mental health to study questions raised by the creation of a separate statute addressing children's commitment needs and to issue recommendations. The substance abuse committee appointed an ad hoc subcommittee on substance abuse to study the revisions needed in the substance abuse commitment law.

During the upcoming months, South Carolina will consider a variety of legislative measures in its effort to revise its involuntary commitment statutes. While legislative consideration of many of the issues relating to the commitment of adults will be delayed until the 1986 session, a pilot project on community screening was established in July of 1985, following a failed attempt to file draft legislation on community screening. Based upon the feedback from this pilot project, state-wide screening legislation could be drafted and submitted to the committee. Draft legislation was filed in April of this year on reducing the detention period that precedes judicial review of commitment petitions.

To address specifically the issues and concerns of South Carolina, the NCSL Mental Health Project provided a program on the commitment of mentally disabled adults and children and substance abusers. The specific problems with South Carolina's commitment laws were identified for NCSL and the consultants by representatives of the respective South Carolina committees reviewing the commitment procedures for mentally ill adults and children and substance abusers. Leonard Rubenstein, legal director of the Washington, D.C.-based Mental Health Law Project, provided an overview of civil commitment laws and conducted the workshop on the commitment of adults. Jay Centifanti, formerly of the New Jersey Divsion of Mental Health Advocacy and currently a consultant with various public interest organizations, led the session on the commitment of substance abusers. Lauren Young, counsel for the Juvenile Justice Committee of the West Virginia Court of Appeals, directed the program on the commitment of mentally disabled children. The

suggestions provided to South Carolina reflect the opinions of the consultants and are not necessarily those of the NCSL Mental Health Project.

SOUTH CAROLINA'S PRESENT COMMITMENT PROBLEMS

The Involuntary Commitment of Adults. In South Carolina, the present commitment law poses many problems. With respect to admissions procedures, the state is experiencing problems with the following:

- inappropriate admissions. Present law does not provide for adequate medical screening to insure that only those people who need inpatient hospitalization receive such treatment;

- transportation and logistics. The state hospital is responsible for handling commitment matters, so once formal commitment proceedings have been initiated, the person under consideration must be transferred to the state hospital.

With respect to treatment and discharge services at the state hospital, different problems with the current law come to the fore:

- periodic review. Current law does not provide for any regular periodic review, nor does it address itself to appropriateness of coupling treatment orders with commitment orders;

- conversion from involuntary to voluntary status. At present, a patient cannot switch from involuntary to voluntary status, thus insuring automatic release when certain conditions are met. Individuals can be held beyond the time when hospitalization is needed or appropriate;

- open-ended commitment. South Carolina is one of three states that still allows for indefinite commitment.

The Involuntary Commitment of Children. With respect to the commitment of mentally ill children, present South Carolina law offers few safeguards to protect them from unnecessary hospitalization and to insure that their basic human and consitutional rights are upheld during both voluntary and involuntary commitment proceedings.

With respect to the admission of children, South Carolina is reviewing the following problem areas:

- responsibility for the commitment of minors. The probate court bears the entire responsibility for the commitment of minors;

- initiation of commitment proceedings. Anyone may file a petition requesting the involuntary commitment of a minor;

- the admissions process itself. The process needs to embrace a better balance between the rights of the children involved and the rights of the parents; at present, parents may place children directly into institutions without any special advocate being appointed to protect the child's interest.

Once the child has been committed, few safeguards are in place to secure appropriate and necessary mental health care and treatment for the child:

- limited treatment options. In many cases, only one treatment option--hospitalization--exists, whether it is warranted or not;

- lack of sufficient interagency coordination. Children often need a mix of mental health, educational, and community-based family services: the present system lacks sufficient interagency coordination and programming;

- lack of program consistency. Present law does not contain programming or licensing criteria that must be followed in the delivery of mental health services to children.

With respect to review and release, the problems of South Carolina's mentally ill children are similar to those of adults: open-ended commitment; a lack of formal review procedures; and a lack of planned and monitored release programs that guarantee continuity of care following discharge from the hospital.

The Involuntary Commitment of Substance Abusers. Regarding the commitment of substance abusers, South Carolina's primary admissions problem is, in part, the result of inadequate treatment facilities for involuntarily committed substance abusers. Thus, both the commitment and treatment of substance abusers in South Carolina is a tangled affair:

- placement of substance abusers. Present law specifies that the Department of Mental Health is not required to accept involuntarily committed substance abusers until separate facilities are available; such separate facilities are not and have never been available to any real degree;

- inappropriate treatment of substance abusers. Substance abusers, in practice, are committed to mental health facilities, which are not designed to address their specific treatment needs and in which they face the same periodic review and release problems as the mentally ill;

- commitment criteria. Present laws contain vague, inconsistent definitions for commitment of substance abusers, as different sections of the statutes were enacted at different times.

POSSIBLE SOLUTIONS TO SOUTH CAROLINA'S PROBLEMS

The Involuntary Commitment of Adults. To protect the rights and to meet the treatment needs of mentally ill adults, South Carolina could make a number of changes in its present commitment law. With respect to admissions problems, the state could do the following:

- establish a local, mandatory screening program to determine appropriate subjects for hospitalization. A good screening system could reduce the number of hospital commitments, resulting in both benefits to the patients and cost savings to the state; care must be taken, however, to protect due process rights in such a program;

- adopt a more local orientation in the commitment process, especially in screening matters. Such a local orientation would encourage community-based treatment and would ease the logistics problems that arise from the state-run commitment system; localities would have to make

arrangements for emergency hospital beds to be used during the screening process.

Regarding the treatment of adults, South Carolina could begin appropriately attaching treatment orders to commitment orders if the commitment law was amended to provide some guarantees. These guarantees could include a reasonable expectation that the person would be helped at the facility and a likelihood that hospitalization was, in fact, the required and most appropriate treatment for the person at that time. Any revision of commitment law needs to be undertaken with the understanding that changes, which make involuntary commitment easier, will not solve the problem of inadequate alternative treatment programs, if such alternative programs are what, in fact, the person needs instead of hospitalization.

To help insure appropriate treatment once the patient is hospitalized, and to help insure his or her timely release, the state could do the following:

- implement strict periodic review procedures, which allow the patient and force the hospital staff to review the patient's progress and to determine the next treatment step;

- establish mandatory and maximum periods of commitment, after which the commitment process begins anew; such set commitment periods help keep people from getting lost in the institutional system;

- start allowing individuals to undergo conversion from involuntary to voluntary status.

Safeguards should be written into the law, however, to insure that a person dangerous to society will not be automatically released following such a conversion. The right to contest commitment can also be subverted by a conversion from involuntary to voluntary status. Therefore, safeguards need to be established, such as right to counsel, which would help guarantee that the person understood what he was doing when he waived his right to contest involuntary commitment, etc.

The Involuntary Commitment of Children. South Carolina's involuntary commitment process for children could be changed to protect the children's mental health, due process, and human rights. To help insure a fair admissions process, the state could make the following changes:

- require petitioners to file through the courts, outlining the child's adherence to certain specified standards for commitment, upon which evidence the court could make a decision; such procedures would lessen the chances for arbitrary action taken against a child;

- define clearly the situations that would warrant emergency commitment;

- shift the "burden of proof" of the child's need for commitment to community-based programs, except in emergency situations;

- outline a general bill of rights for children involved in commitment proceedings, guaranteeing, among other rights, the right to the least restrictive alternative, to housing and treatment facilities distinct

from adults, to appropriate care and treatment, and to family communication and inclusion in the commitment and treatment process;

- establish standards and licensing procedures for the treatment programs and facilities that serve children, giving these programs an overall focus;

- adopt some standard rules of evidence for the court to follow during commitment proceedings, including requiring information from a variey of sources (parents, school personnel, mental health professionals); and

- allow concurrent jurisdiction between the probate court and the juvenile court to speed up the commitment process and to provide for the proper care of delinquent youth involved in judicial proceedings.

South Carolina's treatment procedures could be modified to embrace specified treatment, review, and discharge goals. The state could:

- establish guidelines for periodic review of the minor;

- incorporate into the minor's treatment plan some kind of service plan developed during the admissions/assessment process.

The plan developed during the assessment stage should delineate activities to remedy the minor's problems and the least restrictive alternatives available to address these problems. A full treatment plan should involve the family, the educational system, and other involved service providers. Such a plan might specify the terms of court monitoring, cooperation between agencies, and advance planning on the part of the locales to which the minor will be ultimately released. It could also identify responsible parties and delineate case management, prioritized problems, interventions and needed services, and goals.

Similarly, the discharge plan could be made to reflect the goals and terms outlined in the treatment plan. Discharge could be predicated upon the director of the facility finding that the child is no longer dangerous or mentally ill or that the child would benefit from services in a less restrictive environment.

The Involuntary Commitment of Substance Abusers. To help guarantee adequate treatment and care of substance abusers in South Carolina, the state could begin by clarifying the commitment procedures for both alcoholics and drug addicts. The state could:

- formulate consistent, measurable commitment criteria that focus on chronicity, rather than on the substance abuser's dangerousness to others, and that use such indicators as difficulties with family, health, job, and the law;

- develop a patients' bill of rights, guaranteeing confidentiality, right to refuse treatment, right to a professionally-based treatment plan, right to counsel, and other rights afforded to the mentally ill.

To meet effectively the substance abuser's treatment needs, the state could take a number of steps:

- require the subsequently developed treatment plan to address itself to the chronicity of the abuse and to the substance abuser's rights;

- require a release and discharge plan predicated upon treatment and not upon "drying out";

- amend present law to include maximum inpatient and outpatient treatment periods and to mandate periodic evaluations, consisting of both a review and a formal hearing. One possibility for maximum commitment is ninety days, with provisions for a limited maximum extension.

As the treatment of substance abusers in South Carolina can sometimes lack focus, the state could begin remedying the problems by the following:

- give its treatment of substance abusers some kind of overall focus by establishing a set of standards for licensing substance abuse facilities;

- appoint an interdiciplinary monitoring group to evaluate the quality of treatment at those facilities;

- review the model legislation relating to the treatment of substance abusers prepared by the National Conference of Commissioners on Uniform State Laws.

A major problem facing South Carolina in the treatment of substance abusers is the lack of long-term treatment facilities. A number of possible solutions exist:

- interface substance abuse treatment programs with private facilities;

- develop revenue sources for the funding of treatment programs.

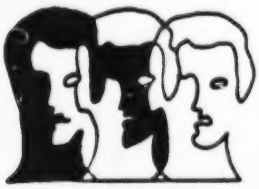
Possible sources for funding include an increase in the excise tax on alcoholic beverages and surcharge fines on controlled substance violations. The state should remain attuned, however, to the potential problems of state interaction in the area of self-help groups.

CONCLUSION

In 1985, the South Carolina Legislature considered, but did not pass, two bills that would have allowed concurrent jurisdiction between the juvenile and probate courts in the commitment of children. The legislature approved a community-screening pilot program in July, now operating in eight county areas around the state.

South Carolina is continuing its efforts to develop a mental health system that will meet both the treatment needs of its mentally ill and substance abusing residents and the financial constraints and humanitarian responsibilities of the state. The state is reviewing various multidiciplinary approaches for the treatment of mentally ill children and adults, working to establish an across-the-state screening program that would operate in harmony with a revised commitment law, and exploring various funding mechanisms for the development of alternatives to inpatient hospitalization.

--NCSL State Legislative Report--16



MENTAL HEALTH PROJECT

TECHNICAL ASSISTANCE PROGRAM TAPES

Available through the NCSL Mental Health Project are tapes of the actual technical assistance program presented for South Carolina on May 10, 1985, in Washington, D.C.

On these tapes, Leonard Rubenstein presents an overview of civil commitment laws and conducts the workshop on the commitment of mentally ill adults. Lauren Young conducts the workshop on the commitment of mentally ill children. Jay Centifanti conducts the workshop on the commitment of substance abusers.

If you wish to recieve loan copies of these tapes, please fill out and return the form below to the Mental Health Project, NCSL, 1125 17th Street, Suite 1500, Denver, CO 80202.

Name: _____

Title: _____

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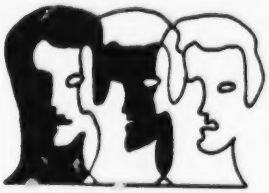

MENTAL HEALTH PROJECT

PROJECT OVERVIEW

In February 1985, the National Institute of Mental Health (NIMH), U. S. Department of Health and Human Services, awarded a contract to the National Conference of State Legislatures (NCSL) to conduct technical assistance programs for state legislators on mental health policy issues.

The goal of the NCSL's Mental Health Project is to improve the decision-making ability of state legislators on mental health policy by providing specific assistance to chosen states and disseminating information surrounding mental health issues.

Through this fourteen month program, the Mental Health Project can respond to specific issue and format needs of legislators. By involving the Panel of Experts, a group composed of legislators and persons with mental health experience, expert consultants, and state policy makers, programs will be developed to provide a variety of services to states, including testimony, special workshops and seminars, and staff assistance.

Based upon input from the state legislatures, ten states were chosen to receive technical assistance with state-specific mental health issues. Along with the programs, background materials, audio tapes, and a State Legislative Report will be developed for each issue area and are available free of charge to requesting parties. The scheduled technical assistance programs include:

South Carolina	Involuntary Civil Commitment	May 10, 1985
California	Mentally Ill Homeless	August 7, 1985
Missouri	Mental Health Services Coordination	September 24, 1985
Kentucky	Mental Health Services for Adolescents	October 3-4, 1985
Pennsylvania	Revolving Door Syndrome of Mental Health Services	October 23, 1985
Virginia	Housing for the Mentally Ill	November 18, 1985
Oklahoma	Community Care for the Chronically Mentally Ill	December 4-5, 1985
New Hampshire	Mandated Mental Health Insurance/ Mental Health Services for the Elderly	January 9, 1986
Michigan	Mentally Ill Offender	January 28, 1986
Oregon	Mental Health Services Funding	March 4, 1986

The Mental Health Project Manager is Rebecca T. Craig, who may be contacted at NCSL's Denver office (303) 623-7800. The federal project officer is Lee Dixon, Office of Policy Development, Planning, and Evaluation, National Institute of Mental Health, at (301) 443-3175.